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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF THE INSPECTOR GENERAL

BOARD & CARE HOMES

A STUDY OF FEDERAL AND STATE ACTIONS
TO SAFEGUARD THE HEALTH AND SAFETY
OF BOARD & CARE HOME RESIDENTS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF THE INSPECTOR GENERAL

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A Study of Federal and State Actions to Safeguard the Health and Safety of Board & Care Home Residents

April 1982

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Executive Summary

In February 1981, Congressman Matthew Rinaldo requested that the Department of Health and Human Services review existing regulations governing the Keys Amendment in order to identify ways of strengthening them. In July 1981, following a preliminary review of HHS activities under the Keys Amendment, Secretary Richard Schweiker asked the Inspector General to complete a study which would identify the "best practices" of States in regulating board and care homes and which would provide a sound basis on which to make policy decisions. This report fulfills the Secretary's request.

The Keys Amendment was passed by the Congress in 1976 in an attempt to address a perceived nationwide problem of lack of standards in board and care facilities. At the time, a series of fires in board and care homes throughout the nation had taken their toll in deaths and injuries to the often elderly and/or mentally disturbed residents.

In response to these fires and other alleged abuses towards residents of nursing homes, Congress held hearings on the problems and considered various legislative approaches to deal with them. This was also the period when the Federal government was advocating "deinstitutionalization" of patients in mental hospitals into the community. Many of these patients, of course, become residents of either boarding homes or board and care facilities, thus increasing the importance of these residences both in numbers and visibility.

The Federal government's efforts to regulate boarding homes and/or board and care facilities was, and is, hampered severely by one basic fact: there is no direct Federal funding of these facilities. Unlike nursing homes for example (skilled nursing facilities and intermediate care facilities) where Federal Medicaid and Medicare programs pay the provider of care directly, there is no similar funding for boarding facilities, or, more specifically, board and care homes. Thus, in 1976 the Congress was faced with a problem over which it had little leverage, or authority to demand standards.

In order to exercise some control over these facilities Congress approached the issue through the only Federal mechanism available, the Supplemental Security Income (SSI) benefit checks paid to the aged, blind and disabled.

Some of the recipients of SSI payments are also residents of boarding and board and care facilities. Congress enacted legislation (the Keys Amendment - Section 1616(e) of the Social Security Act) that required:

1. States to "establish, maintain and insure the enforcement of standards" for residences where "a significant number" of SSI recipients reside or were likely to reside.

2. The Federal government to reduce a recipient's Federal SSI payment by the amount of any State supplement for medical or remedial care if the recipient resided in a facility that was not approved by the appropriate State or local authorities as meeting the standards established by the State. This sub-section is also called the penalty provision.

The most widely criticized part of the Keys Amendment, and the most difficult section to implement, is the penalty provision. The intent of the provision was to provide an incentive to SSI recipients living in substandard (or unlicensed) facilities to move to a licensed facility, one that met State standards.* Such reasoning, however, ignores the fact that SSI recipients are often not physically and/or mentally able to find alternative housing, even assuming that housing that meets State standards is available at all. In addition, the penalty is to be taken against the recipient, a position which has few - if any - defenders. The penalty has never been invoked, and only once was it ever requested to be taken by a State, a request subsequently withdrawn.

We believe the inappropriateness of the penalty and its lack of use is one of the major problems of the Keys Amendment. Though we were unable to identify any feasible substitute penalty, we have recommended that the Department continue to explore possibilities for a new sanction to provide the Department with leverage to enforce the requirements of the Keys Amendment.

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* If enough SSI recipients moved to housing that met standards, it would presumably force owners of sub-standard facilities to upgrade and obtain a license.

The major finding from the Inspector General (IG) review of the Keys Amendment is that there is widespread confusion over the distinction between boarding homes and board and care homes. By its terms, particularly the penality provision language that the SSI payment shall be reduced "on account of any medical or other type of remedial care, provided by an institution...," the Keys Amendment applies only to board and care homes. Boarding homes are residences that simply provide their residents a place to sleep and food while board and care facilities not only offer room and board, but also some form of protective oversight. Thus, the owner (or employee) of a board and care facility might check to see if a resident on medication was taking it according to directions, or help him or her obtain transportation for a doctor's appointment.

Making the distinction between boarding homes and board and care facilities narrows the universe of facilities covered by the Keys Amendment dramatically: our very rough estimates indicate there are 30,000 board and care facilities nationwide, compared with 300,000 boarding homes. As the report points out, it is important that in future public policy discussions, the distinction between the two types of facilities be kept clearly in mind.

While we were in the process of conducting the study, the Social Services Block Grant became law. The block grant removed the connection of the Keys Amendment to the Title XX program. Thus, it is now not clear where in the Federal government States should send "a summary of the standards" or where "each State should certify ... that it is in compliance with the requirements of the Keys Amendment." The report recommends that we clarify these procedures in light of the block grant provisions.

A second change affecting board and care homes was passage of the Rinaldo Amendment to the Older Americans Act in December 1981. By expressly including Keys facilities in the definition of "long term care facilities", the Amendment made inclusion of board and care homes in State's Ombudsman program mandatory.

Finally, the Omnibus Budget Reconciliation Act of 1981 (OBRA) gave the Department the authority to grant "Home and Community Based Waivers" under Medicaid. Section 2176

of OBRA permits states to seek waivers from the Secretary to broaden the definition of "medical assistance" under Medicaid to include certain home and community-based services. The statute requires that in order to grant the waiver, a state must provide assurances that "necessary safeguards are taken to protect the health and welfare of individuals." Further, regulations require that if a state has licensure or certification requirements for any services provided under the waiver, it must assure that standards in licensure or certification will be met.

The IG recommends that the regulation be revised so that to the extent a state requests a waiver for services to be provided in board and care homes subject to Keys, that waiver be granted only where such facilities included within the request meet the standards required to be established by Keys.

The IG report also reviewed current activities in the Department of Health and Human Services, especially Departmental studies and the State Data Exchange (SDX) file. The report indicates:

- Health Care Financing Administration has a memorandum of understanding with the National Bureau of Standards to develop a fire safety evaluation system for board and care homes. Unfortunately, a cutback of funds under the 1981 Omnibus Budget Reconciliation Act threatens completion of this needed work. We recommend completion of this important study with minor modifications in comprehensiveness. It is essential that fire safety evaluation system standards be completed and promulgated in order to assure that the fire safety of covered facilities is adequate.

- In January, 1982, Human Development Services/ Administration on Aging (HDS/AOA) received the final product from the grant "A Nationwide Study of Domiciliary Care." The Six volume final product contains some useful information. We recommend that a synopsis of the policy and program relevant findings be prepared for use by the Department, Congress and the field as part of an overall technical assistance effort.

- Office of the Assistant Secretary for Planning and Evaluation (ASPE) has funded a contract to provide an evaluation of board and care homes. There appears to be some duplication with the AOA grant.

- Social Security Administration (SSA) is funding a secondary analysis of the AOA study, focusing on how States that provide SSI supplemental payments supervise board and care facilities. The report should be finished in May.

Overall, we found a lack of coordination between the various components of HHS that funded board and care research, as well as considerable tardiness and lack of rigor in the products. One of the recommendations of this report is that the Department designate a single unit, responsible for coordinating board and care activities and providing Departmental leadership to prevent the overlap and duplication we found.

SSA has the capacity to provide the States with SDX tapes listing SSI recipients by address, thus giving the States the ability to determine residences where three or more SSI recipients are living. Such information can be of assistance to States in determining the location of board and care facilities. Although SSA has offered this assistance to the States in the past, we recommend the States be notified again that it is available as part of increased HHS technical assistance efforts.

The results of a telephone survey conducted for this study of State board and care licensing and enforcement entities revealed that States are well aware of the Keys Amendment, and most States seem to be making progress in upgrading their facilities over the past several years. However, States are limited by a lack of ability to close a facility that does not meet licensing standards. Some States have been able to close facilities almost immediately by using fire marshals. However, States can be stymied by lengthy court proceedings, used by owners of substandard facilites to delay closing. We recommend that other States consider systems like the one established in Pennsylvania, in which persons needing protective oversight are placed in "Domestic Care Units" and provided increased SSI State Supplemental payments. These and other best practices are described in the body of this report.

In conducting our study one of the questions we asked State officials with whom we talked was what kind of activities the Federal government could undertake to help States fulfill their obligations under the Keys Amendment. In addition to the need for technical assistance from the Federal government, States pointed to the desirability of having the Federal government help them define a model state statute for board and care homes. We recommend, therefore, that the Department, perhaps together with major national organizations broadly representative of State and local concerns and other standard setting groups knowledgeable in the field develop a model statute for use by States. This recognizes the shared responsibility for board and care homes across all levels of government.

Because of the inherent problem of attempting to oversee facilities where the only Federal involvement consists of benefits paid to residents of those facilities, we sought to identify situations where payments were made directly to board and care homes (or their proprietors). Currently, where SSA determines that it is in the interest of an SSI recipient, payment of benefits may be made to a concerned third party on his behalf. This third party, the so-called representative payee, may be a board and care operator. Because of the potential for fraud in such a situation, we have recommended that SSA more strenuously enforce its existing regulations and consider approving representative payee status to board and care proprietors only if the proprietor submits to SSA evidence of compliance with applicable State standards.

Conclusion

In conclusion, though the study problems with implementation of the Keys Amendment, it also defines opportunities for Departmental action which could facilitate the efforts of the many levels of government and the public and private organizations and individuals engaged in carrying out Keys Amendment responsibilities. We believe such efforts would ultimately improve the quality of board and care homes and the lives of citizens living in such facilities. Specifically, the study recommends the Department:

1. Establish a single unit in the Department with responsibility for providing Departmental leadership, and coordination of, board and care issues.

2. Clarify procedures for State certification of compliance and publication of standards, in light of the block grant provisions effecting Section 1616(e).

3. Consider establishment of a new sanction to give the Department leverage to enforce the requirements of the Keys Amendment.

4. Grant Medicaid home and community based services waivers only to States certifying their compliance with the Keys Amendment.

5. Establish greater protection against fraud for SSI board and care recipients in the SSI representative payee program.

6. Increase technical assistance to States.

7. Develop a model State statute for board and care homes.

8. Complete the development of fire safety standards for publication in the Life Safety Code.

Introduction

Purpose of Study

The Keys Amendment, which attempts to address the problems of standards in nonmedical group living facilities, has proven to be a faulty and difficult law. The Secretary of Health and Human Services, in July 1981, asked the Inspector General to determine what the Department could do to facilitate more effective State and local administration of standards in facilities covered by the Keys Amendment. In response to the Secretary's request, the Office of Inspector General (OIG) conducted a review to identify and describe the activities of those States and localities which, on their own initiative, are effectively developing, setting and enforcing standards at a relatively reasonable cost.

Subsequently, the Under Secretary, in testimony on July 28, 1981, before the House Select Committee on Aging, made commitments to broaden the Inspector General's study to include not only the best practices of States and localities but also to respond to specific inquiries made by the Committee. Some of the specific questions raised are included in a separate technical report, while broad issues such as definition of board and care homes, technical assistance, Departmental studies (including the requirement for sprinkler systems) and State practices are in the body of the report. The technical report also includes a synopsis of State statutes and regulations covering licensing and enforcement.

The report is in four parts. Part I gives an overview of the history and intent of the legislation. The legislative language of the Keys Amendment has caused definitional and jurisdictional problems. These became evident as the Department attempted to implement the law. These problems are discussed in the report.

Part II describes the Department's efforts to comply with the intent of the law. Departmental technical assistance activities, a memorandum of understanding, grants and contracts focusing on the board and care home problem are described.

Part III provides a description of what States are doing to license, regulate and enforce their own standards. Innovative or "successful" methods employed by States are contained in our "best practices" section. Because the problem of referral to unlicensed facilities often begins at the time of discharge from public institutions, we have included a section on placement, referrals and resources.

The fourth part of the report summarizes the major issues and makes recommendations for their solutions.

Scope of Study and Acknowledgements

We reviewed and summarized State laws and regulations pertaining to licensing and enforcement of State standards and chose the following States for followup discussions about their practices: California, District of Columbia; Florida; Illinois; Maryland; Michigan; Missouri; New Jersey; New York; North Carolina; Pennsylvania; and Virginia.

In addition, we reviewed Departmental reports, contracts, grants, agreements and interviewed relevant officials regarding the original objectives and current status of these studies and reports.

We also met with special interest groups to determine the extent of their activities on board and care issues and to obtain from them the information gathered through their efforts. We are particularly grateful to The National Citizens Coalition for Nursing Home Reform who allowed us to review State surveys they performed. Our appreciation also to countless State and hospital staff who contributed data generously and often on very short notice.

Background and Legislative History

On October 20, 1976, Congress enacted Section 505(d), of P.L. 94-566 (called the Keys Amendment). This law became Section 1616(e) of the Social Security Act (Appendix A).

The Keys Amendment was initially proposed as part of H.R. 8911, Amendments to the Supplemental Security Income Program, adopted by the House of Representatives in 1976. A pertinent part of that original bill required States to establish standards governing group living facilities, in which a significant number of SSI recipients resided or were likely to reside, to publish those standards annually (together with any waivers granted or violations found by the State), and to certify annually to the Secretary that each State was in compliance with the above requirements. No further enforcement provisions were incorporated in this bill.

Although the House Bill (H.R. 8911) was not passed by the Senate, the Senate did adopt a similar provision as part of a later bill. That provision incoporated the substance of the Keys Amendment, and added the penalty provision now contained in Section 1616(e)(4) of the Social Security Act--a dollar for dollar reduction in Federal SSI benefits for any State payments made for medical or remedial care to an SSI recipient residing in an institution which failed to meet the relevant State standards. The provisions governing eligibility of SSI recipients became effective October 1, 1977.

The legislative history indicates that Congress was concerned that Federal SSI benefits not be used to support substandard living facilities. Although the provision superseded by the Keys Amendment (requiring Federal SSI benefits be reduced where payments were made by States for care which is or could be provided in a Medicaid institution) proved unworkable, Congress sought to ensure that States would establish and enforce standards for such group living facilities. (It should be noted that in another portion of the Keys Amendment not at issue here, Congress recognized the benefit of placement of some individuals in small residential settings and so lifted the bar on payment of SSI benefits to persons in public institutions of less than 16 residents.)

Under the provisions of the law, the standards set by the State "shall be appropriate to the needs of such recipients and the character of the facilities involved, and shall govern such matters as admission policy, safety, sanitation, and protection of civil rights." The Keys Amendment calls for a summary of the standards to be published in the State's annual program services plan under title XX of the Social Security Act and for the State to certify each year that it is in compliance with the requirements of Section 1616(e). However, with the passage of the Omnibus Budget Reconciliation Act of 1981, and the conversion of Title XX social services to a block grant, the requirement that Keys standards be published in the title XX annual Services plan was eliminated. Therefore, although the Keys Amendment still mandates that relevant standards be published it no longer specifies where publication must occur.

CURRENT HHS ACTIVITIES -- DEPARTMENTAL STUDIES AND DATA EXCHANGE FILE

- HCFA -- Fire Safety Evaluation System for Board and Care Homes

  Development and Preparation of Technical Assistance and Promotion tools -- Inspector's Manual on Fire Safety in Boarding Homes and Boarding Home Safety Media Kits

- HDS/AoA -- Nationwide Study of Domiciliary Care

- ASPE -- Evaluation of Board and Care Homes

- Other Departmental Efforts--NIMH and SSA

Health Care Financing Administration

Despite long-term involvement in the areas of life safety and fire safety for occupants of medical care facilities, particularly nursing homes, the Health Care Financing Administration (HCFA) has entered only recently into the board and care arena. The reasons for this are many, including other pressing issues and actual enforcement responsibilities, and the nebulous definition of board and care facilities itself.

In the last years, however, as interest and debate over the Key's Amendment grew, HCFA entered into two contracts, both interagency agreements dealing with fire safety in board and care homes. Due to HCFA's lack of enforcement authority over such providers, the contracts reflect a voluntary approach, stressing standards development, distribution and promotion rather than mandatory requirements and Federal review. The two studies are summarized below, along with a brief description of one project which was proposed but not funded.

I. Interagency Agreement between the National Bureau of Standards (NBS) and the Department of Health and Human Services (DHHS)--General Agreement for Applied Engineering Research and Development, Test and Evaluation.

The broad purpose of the agreement was to support research that "would result in standards for facility design in support of programs and facilities." Handled through the Office of Facilities Engineering, DHHS, the intent was to establish an ongoing mechanism through which different components (OPDIVs) could identify research and development needs which would be structured into "Work Statement" activities to be performed by NBS.

This particular agreement/work statement, signed in January 1981, involved a work plan prepared by HCFA for the development of a Fire Safety Evaluation System (FSES) for board and care homes. In addition, it designated research to be conducted in the areas of furniture combustibility, safe egress time, hazardous space, sprinkler protection, etc., as they related to such facilities. While

the work plan required the completion of the draft FSES by the end of the fiscal year, refinement, publication and adoption activities were expected to continue through FY 1982, as were the other research efforts. $965,000 were approved for FY 1981. The sole source agreement was justified on the basis that NBS had been conducting ongoing research for the Department in the areas of life and fire safety since 1974. They also had a strong affiliation with the National Fire Protection Association, the group through which HCFA hoped to promote the FSES. The FSES and standards to be developed were to become part of the life safety code.

The actual work plan stated that NBS would, over a two-year period:

- o develop, approve and promote a fire safety evaluation (and equivalency) system(FSES) for board and care homes;
- o do a sprinkler decision analysis;
- o conduct three pilots looking at the cost optimization application of FSES;
- o research the calculation of safe egress time, furniture combustibility, hazardous areas, with an emphasis on risks found in board and care homes, etc.--all dealing with rational engineering alternatives and upgrading the FSES's; and
- o conduct actual tests of sprinkler protection in both health care and board and care facilities.

Due to the lack of clear Federal enforcement responsibilities, the FSES was to be developed as an equivalency system, affording individual States and providers some flexibility in the adoption of code standards. The intent was the ultimate provision of an overall equivalent level of fire safety for all board and care residents.

While some of the tasks represented continuation of ongoing NBS research, the main focus of the agreement was clearly on fire safety and special

risks presented by board and care facilities. However, according to the status report dated August 18, 1981, NBS projects $825,000 in FY 1982 funding to adequately complete the tasks outlined.

While a first draft of the chapter for the Life Safety Code was submitted to the National Fire Protection Association in January, HCFA has stated that there is no more money in their budget to continue the research.

The seal of approval from NBS, needed before the standards can be actively promoted for the States, will not be on until at least February, 1982. Given HCFA's lack of enforcement authority over board and care homes, the best role they see for themselves now is as an active supporter, distributing the standards and providing technical assistance and training to the States as requested. They also hope to use their affiliation, and NBS', with the National Fire Protection Association, to encourage States' voluntary use of the FSES.

II. Interagency Agreement Between the Federal Emergency Management Agency (Fire Administration) and DHHS/HCFA/ Health Standards and Quality Bureau (Division of Program Analysis and Training)

The project objective, broadly, was to convene a task force to identify and prioritize key issues of fire safety in boarding homes. Those issues were to form the basis of both the preparation of a media publicity kit and the development and delivery of three Regional Issues Seminars.

The sole source agreement was justified based on the Fire Administration's (USFA's) long-term involvement in the field and the potential for successful dissemination of the materials. The period of performance was projected to be March 4, 1981 - September 30, 1981, at a cost of $184,950.

The specific services to be furnished by USFA included the following:

- o to identify and convene a Task Force on Fire Safety in Boarding Homes, to be composed of ten individuals with expertise related to that specific issue;

- o development and delivery of a series of three Regional Issues Seminars on Fire Safety in Boarding Homes, which will incorporate issues identified by the Task Force. These have been held;

- o preparation of a Boarding Home Fire Safety Media Kit for presentation and promotion during those seminars, the primary message of which is to consider fire safety when selecting a boarding home; (This task has been cancelled);

- o development of an Inspector's Manual on Fire Safety in Boarding Homes. A draft has been complete; and

- o preparation of a composite report following the seminars on both the content of the proceedings and the status of State actions to date including best practices. This has not been received by HCFA.

A dissemination plan, written into the agreement, stated that duplication and distribution of the Media Kit would be the responsibility of HCFA/HSQB, taking into account USFA's advice on strategies, while USFA would publicize the availability of the materials in their Fire Education Resource Bulletin. (USFA has not yet done this.)

HSQB has done no other work to date on board and care homes. They proposed, however, in their FY 1982 internal work plan, to develop an analytical report reviewing all existing studies and State standards for board and care facilities. The purpose would be to identify the nature of the need for Federal intervention and/or regulatory changes. There was a projected completion date of June 1982, but the project was not begun because of funding difficulties.

Finally, in addition to the two projects currently underway, one other contract was proposed for FY 1981 dealing with the "Development of Model Ordinances and Procedures for Fire Safety in Boarding Homes." The contract was requested by HSQB, as were the other two. To go out for competitive bid, the estimated cost was $813,794. While announced in the Commerce Business Daily, funds were pulled back at the last moment and a formal Request for Proposal (RFP) was never issued.

The proposed purpose of this contract was "to develop Model Ordinances, Model State Legislation, and a technical assistance package for implementing the ordinances to be distributed to the States for their use to improve life safety for. . . .residents in these boarding homes." A project advisory group would have been used in designing the standards, as was the case in the Fire Administration agreement. HSQB had already obtained a letter indicating the support of the President of the Association of Health Facility Licensure and Certification Directors when funding was dropped.

Like the other two funded projects, this proposal reflected the voluntary, nonenforcement posture HCFA maintains (must maintain given current laws and regulations) regarding board and care providers and State responsibility. It would have gone a step further, by developing actual model standards and legislation and providing technical assistance to facilitate their adoption.

Just as HCFA's efforts in the board and care arena were variations on a common theme--fire safety--so were the projects funded by three other divisions with the Department--the Office of the Assistant Secretary for Planning and Evaluation (ASPE), Social Security Administration (SSA), and Human Development Services, Administration on Aging (HDS/AoA). In these cases, the shared emphasis was on regulation and enforcement of State board and care (or domiciliary care) standards, and the varying needs of the homes' residents.

These objectives, were to be reached via a three tiered research strategy:

1. A literature search and secondary analysis of existing data (data obtained from earlier studies conducted by HRCA and a subcontractor);

2. a 50 State analysis of existing domiciliary programs characteristics, including standards and regulations (to be conducted by a subcontractor); and

3. case studies in six States to test hypotheses suggested from activity number 2, including client and provider interviews.

After significant time delays and a dearth of material from the grantee, the grantee submitted several deliverables in the fall of 1981 and the final 7 volume product in January 1982. The seven volumes are titled:

1. Summary and Report of the National Survey of State Administered Domiciliary Care Programs in the Fifty States and the District of Columbia.

2. State Regulations Governing Domiciliary Care Facilities for Adults and the Relationship between Standards to Program Characteristics.

3. Report on Administrative Structure of Domiciliary Care Programs Serving the Elderly in Six States.

4. Domiciliary Care clients and the Facilities in which they Reside (3 volumes)

5. Targeting Applicants to Supportive Community Housing for Special Service Initiatives.

Due at least to the sheer volume of the material, we have recommended that AoA provide the Department with a policy relevant synopsis of findings.

Human Development Services/Administration on Aging

"A Nationwide Study of Domiciliary Care" (Grant Number 90-A-1659)

Awarded competitively, in October 1978, to the Hebrew Rehabilitation Center for the Aged (HRCA), at a cost of $405,081, the primary goal of this project was "to determine the availability and cost of domiciliary care (i.e., board and care) and the services that are provided to older persons in supportive residential settings."

The projected period of performance was October 1, 1978 through December 31, 1980, however, two no-cost modifications have extended the grant completion date to September 30, 1981, with a December deadline for the final report.

The stated research objectives of this grant included the following:

- o To determine the supply of different types of domiciliary care for the elderly;
- o to determine the costs of each type of domiciliary care for elderly;
- o to assess the impact of Federal and State policies on the supply of supportive residential settings, including funding sources and regulations, licensing requirements and limits on entry of service providers;
- o to determine how elderly persons enter these facilities;
- o to identify types of services provided to elderly residents of such facilities;
- o to identify the extent and types of linkages between these facilities and other community providers;
- o to assess the appropriateness, adequacy, and quality of domiciliary care services, based on the needs of elderly residents, by such facilities; and

- to identify the characteristics and levels of impairment of elderly persons who are best suited to be served in each type of facility.

Office of the Assistant Secretary for Planning and Evaluation

"Evaluation of Board and Care Homes" (Contract Number 100-79-0117)

This study, awarded to the Denver Research Institute (DRI) in September 1979, one year after the AoA project was begun, was to be a review of "board and care homes and the various systems that have been developed for managing services to the disabled and elderly residents in homes that require some level of protective services."

The scope of work, as originally defined, was expected to require two years to complete, though the contract was for one year with a one year option. The following tasks were to be accomplished: (Condensed from the RFP and contract work statement.)

1. The contractor will collect from the States, review and assess the standards by which board and care homes are evaluated pursuant to the Keys amendment. It will in addition, develop a model set of standards against which the State standards can be compared.

2. The contractor shall summarize which State and local agencies are involved in regulating board and care homes and the extent of their control, the extent to which the applicable regulations are actually enforced, and the effectiveness of these community controls in promoting appropriate community care. In addition, the contractor shall assess the extent to which the States are enforcing the standards under the Keys amendment. Finally, the contractor will identify enforcement mechanisms that may be developed to enforce standards at a State and a national level.

3. The contractor shall review the literature related to board and care homes and other special housing or congregate living arrangements for the handicapped. Emphasis shall be placed

on those studies providing empirical evidence of actual client outcomes. The contractor will develop short summaries and methodological critiques of those studies which document client outcomes, services utilization and associated costs.

4. The contractor shall prepare two initial reports to HHS based on the literative review and "other knowledge and experience the contractor has available." (The specific questions to be covered were listed.)

5. Upon approval of the report in Task 4, the contractor shall prepare a plan for collecting new data, with a multi-focus on standards enforcement, client/resident ability to function and needs, and community support systems. The questionnaires and interview guides will be developed as well as preparing all supporting documents required for OMB clearance of those instruments.

   A sample, consisting of 10 geographically dispersed States, ca. 50 homes/State, will be drawn. It will consist of only non-Medicaid certified facilities that provide protective and other services. (The sample size and design was changed in October 1980, when the scope of the whole project was expanded.)

6. The contractor, upon receiving OMB approval of the data collection instruments, will collect, verify, and analyze the data obtained and present it in one report at the end of year one (on 30 percent of the data) and another report, to be prepared during optional year two on the remaining data. In addition, the final report will summarize the findings from all parts of the study.

The total cost to the Department is now set at $1,220,441 for the whole contract. Tasks 1 through 4 were subcontracted by DRI to Boston University and the Hebrew Rehabilitation Center for the Aged. The subcontract had Drs. Clarence and Sylvia Sherwood, of Boston University and HRCA respectively, as co-directors of the research effort. The subcontract, which was not a part of the original

competing Denver Research project, was initiated at the urging of the HHS project officer five weeks after the original contract was signed.

Meanwhile, during the developmental and literature review phase, ASPE decided, with the contractor's agreement, to expand the focus of the survey effort. From homes covered under the Keys Amendment, the study shifted, in October 1980, to include Intermediate Care Facilities and single room occupancies (SROs) with the resident sample aimed at equal proportions of aged, mentally ill and disabled. This had the effect of tripling the complexity of the project. As the Request for OMB Approval stated: "Via direct onsite interviews, the Denver Research Institute will assess and evaluate the needs and capabilities of the mentally ill, mentally retarded, and elderly living in board and care homes, Intermediate Care Facilities (ICF-MRs), and single-room occupancies (SROs), will determine the conditions under which these disabled populations are living in the community, and the degree to which States are in fact regulating these facilities, and from the data suggest policy and program changes that will more adequately meet the human service needs of these persons." The cost to the Federal government was to remain the same.

The contract has now entered its third year. A one year extension, which also increased the total amount of the contract by $328,227, was granted to allow for the modifications in the projects focus, and delays in OMB clearance. The project officer reports that DRI has completed data collection and is now putting the information in the computer. The final report is expected close to the new due date of September, 1982. The reports from the subcontractor, received one year late, were considered unacceptable by the project officer and were returned for major revisions, which were made.

According to the project officer in ASPE, there are three major differences between their contract and AoA's grant, making it, in his opinion, a stronger and more policy relevant piece of research: 1) the change in focus to include alternate residental settings (e.g., ICF-MRs and SROs); 2) the intent to include, to the extent possible, unlicensed board and care homes, as opposed to AoA's focus on licensed homes; and 3) a more indepth data collection effort, emphasizing client condition through clinical analysis.

Social Security Administration

"Study of Domiciliary Care Facilities"
(Contract Number 600-79-0096)

This contract, also awarded competitively, to the Hebrew Rehabilitation Center for the Aged (HRCA) approached the subject and problem of domiciliary care from a perspective slightly different from that addressed by AoA and ASPE. That is, it recognized existing data limitations and focused on how States with SSI supplemental programs supervised domiciliary (or board and care) facilities. It also was clearly directed towards the current issue of whether the Federal government wants (or needs) to assume a more active role in the area.

As stated in the study justification, "the information sought in this procurement will provide the basis for further evaluation of the present Federal program in meeting the needs of SSI beneficiaries. In addition, it will assist in developing Federal policy regarding the future role of (DHHS) with respect to the funding and regulation of such programs..." The specific purpose of the procurement was "to generate systematic information on domiciliary care facilities under both Federal and State administrated optional supplementation programs for those States which make special provisions for such care."

In order to accomplish the objectives detailed above, the contractor was to:

1. Extensively interview State and local agency staffs responsible for domiciliary care facilities and related matters in selected States and analyze data. (The 17 States selected by SSA--9 Federally administered and 8 State administered--covered approximately 90 percent of the persons identified as receiving State supplements in domiciliary care.)

2. Develop various analytical models for a domiciliary care facility-related payment under varying assumptions (i.e., Federal or no Federal participation).

3. Prepare a draft final report for the project. This report would include the results of the interviewing from Phase 1. It would also include the various assumptions dealing with Federal participation. Upon approval by SSA, a final report was to be prepared and submitted.

The total cost of the contract was set at $223,321. The projected period of performance was September 30, 1979 through December 31, 1980. In October 1980, however, a no cost extension was requested and granted, changing the completion date to no later than September 30, 1981. The reason given was a delay in OMB clearance of the data collection instruments. In February of this year, OMB disapproved the questionnaires. It did so again in March when asked to review the decision. The reasons given were: 1) The study had limited use due to the selection criteria for the 17 States of the 35 with optional supplementation programs; and 2) the study was of low priority and of a policy sensitive nature.

SSA originally spent $72,000 of the total amount approved. For that, they have received a survey methodology, including pretested questionnaires, and a literature review. The Office of Research and Statistics entered into a partial termination of the contract, with HRCA conducting a series of "secondary analyses" with data obtained from other HRCA studies, including their current study of domiciliary care conducted for AoA. The additional cost for the revised analysis is estimated to be $40,000 (in addition to the $72,000 already expended). SSA has received a draft report, and expects the final report in May.

State Data Exchange (SDX) - Tape Runs

In 1979, the General Accounting Office (GAO) conducted a review titled: Identifying Boarding Homes Housing the Needy Aged, Blind and Disabled: A Major Step Toward Resolving A National Problem. In this report - which cited unsafe and unsanitary living conditions in boarding homes housing many SSI recipients, GAO indicated that many State and local licensing inspection officials do not know the location of these unlicensed facilities.

GAO recommended that Social Security Administration (SSA) records, specifically the State Data Exchange file (SDX), be used to assist in locating boarding homes housing SSI recipients. The SDX file contains a current listing of SSI recipients including beneficiary name and address. For those States needing computer programming assistance, it recommended that SSA provide assistance in manipulating the SDX file into a usable format for identifying potential boarding homes by identifying addresses on the SDX tapes where three or more recipients resided.

SSA concurred with this recommendation, and in August, 1979, SSA sent an Information Memorandum to the State Agencies administering the Title XX Social Services Programs advising them of this programming assistance. States were told to contact their SSA/SSI Regional Office to request these special tapes.

Since November, 1979, SSA has record of some 17 States having requested these special computer runs of groups of 3 or more SSI recipients at the same address. Most requests were made in early 1980, although a few have come in this past Summer of 1981. Based on telephone calls to 14 of the above 17 States, as well as calls placed to an additional 3 States, we found the usage made of these tapes to be spotty. Some States had used the tapes occasionally to spot check their own list of facilities, where others had used them only once. Some State agencies found the data old, and others upon receiving the tapes did not seem to know how best to use the data. At least one State Agency had never heard of the special tapes. Finally, some States could not use the data effectively because they could not access their own State records with the tapes, or had a population that included facilities serving two or more individuals, or found that the rural listings did not include box numbers along with the Route Number. (Some routes are 30 to 50 miles long in certain rural areas.)

One possible reason for some of the States either not requesting the files, or not really using the data effectively upon receipt, might be due to the lower priority placed on outreach activities by the States. Additionally, the Title XX agency in the State is generally not the same agency responsible for licensing or inspecting the board and care facilities. Thus the November, 1979, notice may have not reached the right party.

Finally, the OIG has developed--for other purposes--an address standardizing computer program. Through discussions with the GAO audit staff who developed an address scanning program for SSA to use with the SDX tapes, we found that a combination of the OIG software along with the SSA software might result in an improved data file for the States to use. We are currently working with SSA staff to test the various programs so that a better product will result.

Other Departmental Efforts

Previously discussed research comprise the universe of projects directly concerning board and care homes conducted or funded by DHHS. Additional work, however, has been done by SSA and the National Institute of Mental Health (NIMH).

Within the Social Security Administration, the Office of Assistance Programs; Office of Insurance Programs; the Office of Security and Program Integrity; and the Office of Research and Statistics all handle policies, programs, research or statistics, which impact the board and care population.

The SSI policy branch has worked closely with the Office of Research and Statistics, since it is that group which has responsibility for collecting all data on optional State supplementation programs. Information is submitted regularly by those States, providing the number of people receiving supplementary payments and their average dollar payment. SDX tapes containing names of SSI recipients who receive supplemental checks for medical and remedial care are available upon request for individual State's use.

The representative payee is handled by the Office of Insurance Programs. Representative payees are designated when recipients are determined to be incapable of managing their own funds. Once that determination has been made, a representative payee is named by the program or agency and will be responsible for seeing that housing and food, and possibly, utility bills are paid for the recipient. Tremendous potential exists for representative payee for fraud and abuse in the board and care areas, particularly in situations where there has been no change in the case status and checks continue to be mailed out over a long period of time. SSA Regional/field offices, particularly New York and New Jersey, have done extensive work in the area and feel they have only begun to uncover problems and abuses that exist.

While the Office of Insurance Programs has conducted studies of the representative payee process, none have dealt directly with board and care residents. Rather, they have tended to look at the SSI recipient in institutions. They did, however, assist GAO in their study

of board and care homes in 1979. GAO is now in the developmental phase of a new study looking at the use of representative payees in 17 Federal payment systems to determine what controls are in place to assure that recipients get the use of their funds. GAO does expect to identify board and care homes as a high risk area and hopes to work with SSA to resolve some of the problems.

The National Institute of Mental Health's concern rests with the adequacy of such facilities as community residences for the chronically mentally ill deinstitutionalized population. While no studies have been conducted on board and care homes, per se, they have been addressed repeatedly, particularly as they relate to the "continuum of care" to be developed in the model Community Support Programs.

CURRENT STATE ACTIVITIES

- Survey of State Licensing and Enforcement Practices.
- Survey of State Placement, Resources and Referral Practices (selected hospital discharge data).
- Best Practices.

Survey of State Licensing, Inspection and Enforcement Practices

The primary purpose of this survey was to collect information on States' licensing, inspection and enforcement practices and to highlight, where possible those practices which were thought to be practical and effective. Also, we were requested to obtain information about the States' use of incentives, penalties, publicity or technical assistance to get compliance; their use of oversight (legislative, administrative, voluntary); impact of Keys Amendment; use of SDX tapes; availability of resources and protection of residents' rights and funds.

The survey found that workable statutes, clear regulations, and well trained inspectors who can give technical assistance to board and care operators were the most important ingredients for enforcing standards. Of secondary importance was the degree of oversight, publicity and interest generated by State legislatures, officials or voluntary interest groups. Third, are the support activities, i.e., training for board and care operators; monetary incentives or penalties for upgrading and compliance; and systems for reporting special problems such as ombudspersons and hotlines. All States indicated that they could benefit from more mutual sharing of information and saw the Federal Government as facilitating the process.

Activities outlined in the following 12 States refer primarily to board and care facilities. However a few States, most notably New Jersey and Maryland have begun the initial steps of locating, identifying and referring unlicensed homes for licensing. Project Identification in Maryland and Statewide Regulation of Compliants under the Room and Boarding Homes Act of 1979, in New Jersey are highlighted as examples. North Carolina, in a Service Delivery Assessment on Boarding Homes, indicated that estimates of the number of unidentified homes Statewide ranges from nil to five.

California

Agency for Licensing, Inspections, and Enforcement

State Department of Social Services, Community Care Licensing Division responsible for all licensing except SNFs and ICFs.

Funding for licensing/enforcement is through the State General Fund.

- Prior to 1979, some Title XX was used.

Facilities Regulated

Residential Facilities and Social Rehabilitation Facilities are covered (defined in summary of California laws and regulations).

Licensing

- Approximately 6,000 Residential Facilities
  3,000 Group Homes and 3,000 Family Homes
  200 Social Rehabilitative Facilities

- Outreach

  - o Licensing Division provides an orientation and information to licensee in preapplication stage.

  - o Some agencies recruit organizations/people to open facilities (e.g., Department of Mental Health had sent money approximately $3 million - through the Community Mental Health Residential Treatment Program for the development of new facilities).

- Provisional license -- facility is in substantial compliance (problems may exist, but nothing which is a health and safety risk). Approximately 25 issued a year.

  Regular license -- facility is in full compliance (no problems identified).

  If facility fails to receive a provisional or regular license, application is still pending.

- Denial of new application -- facility cannot operate until application is cleared.

Revocation of a license -- facility can continue to operate pending appeal. If revocation stands, the operator can not be licensed again for 2 years.

Suspension of a license -- occurs when there is an immediate danger to health and safety of resident. State is able to close facility within 24 hours. After closure, an appeals hearing must take place in 2 weeks. The community care law authorizes Division of Community Care Licensing to suspend a license.

Inspection

- State has 84 inspectors
- Inspectors are assigned, geographically, then if the area is large (e.g., Los Angeles) they are divided up by facility type.

Enforcement

- Technical Assistance -- provides consultations in upgrading facilities.
- Rules are "fairly" enforceable. Some do not require documentation -- making determination of compliance more difficult. Also, state does waive some rules. Larger, better financed facilities are more capable of handling penalties but at disadvantage because larger facilities have tighter and more specific rules.
- Penalties -- facility is required to develop a plan of correction if not in compliance. Failure results in civil penalties of $25 (for 1 to 1,000 minor violations) to $50 (for violations of an immediate threat to resident) for each day of noncompliance.
- Division of Licensing investigates any complaint within 10 days of receiving it. All inspection reports are public information.

Best Practices

- The threat of civil penalties has been successful.
- Denial of a renewal license.

Patients' Funds

- Operators must be bonded in order to handle resident funds; operator must notify State who will handle funds, how, and what amount.

- License revoked if funds are mishandled.

- Specific documentation (e.g., ledgers, recipients) required.

- Review patient fund process during license application renewals, and for specific complaints.

Legislative and Voluntary Oversight

- Oversight Authority: State Legislature through reviews performed by their Auditor General.

- Legal Basis: California Community Care Facility Act of 1973 - introduced by Assemblyman Launderman, Ventura, California.

- Legislators - Senator John Garmendi
  - Assemblyman Bates (Mental Health)
  - Senator Presley (Child Welfare)

- Special Interest Groups - California Association of Residential Homes
  - Society of California Community Care Operators
  - California Association of Homes for the Aging
  - California Association of Health Facilities

- Advocate Groups - NOVA
  - Network Against Psychatric Assault

Departments in California involved in Community Care which DSS licenses:

a. Mental Health Department
b. Development Services Department
c. Aging Department
d. Social Services Department

District of Columbia

Agency for Licensing, Inspections and Enforcement

Department of Human Services (DHS), Licensing and Certification Services

Facilities Regulated

Community Residential Facilities (CRF)

Licensing

- 326 licensed facilities.
- About 5 over 50 residents.
- No provisional licenses. The licensing office works with the facility to bring it up to standard.
- Outreach is not done, as there are empty beds in the District now. More outreach needs to be done to get people living alone to homes that provide protective care.
- Facilities have 30 days to come into compliance.

Inspection

- Six inspectors, a nursing consultant, a pharmacist, an environmentalist and a person from the fire department.
- Assigned mostly by geographic area.

Enforcement

- The District has been working with some operators for over a year to bring them into compliance.
- DHS needs stronger legislative authority to close board and care homes. Because owners go to court, the process is lengthy.
- In order to close facilities without going through the court process, the licensure office uses the fire department, environmental services or the Adult Protective Agency.

- Regulations are more prescriptive for facilities with over 50 residents. (The State SSI supplemental is also higher to these residents--$237.20 vs. $127.20.)

- Refused to license about 3 facilities; about 10 facilities voluntarily withdrew.

Patient Funds

Inspectors do look at handling of patient funds. Patient funds are a problem, especially in the larger facilities.

Best Practices

- The District of Columbia has a patient referral system, the Central Referral Bureau (CRB). CRB keeps a list of all licensed facilities, which it tries to match with peoples' needs when protective care is required.

- Educational courses are required for Community Residential Facilities (CRF) operators (as part of the Dixon decision implementation plan).

- A professor from Howard University and community groups worked with insurance companies and produced insurance policies available to CFR operators for fire and liability at a reasonable price.

- St. Elizabeths Hospital is now referring discharged patients only to licensed CRFs.

Florida

Agency for Licensing, Inspections, and Enforcement:

Department of Health and Rehabilitative Services,
Aging and Adult Services Program Office

Funding Sources

General Revenue: 25%
Older Americans Act: 75%

Facilities Regulated

Adult Congregate Living Facilities:

- Type I - Provides room, board, housekeeping, leisure activities, aids in securing health care, etc.
- Type II - Provides above plus supervises self-administered medication, more extensive personal care needs.

Licensing

Number of Facilities: 749 No. of Beds: 3,000

Outreach: Coordinates with hospitals, Health Department, VA, etc. regarding referrals. Works with Hotel and Restaurant Commission to detect board and care facilities. Reviews ads in papers to identify homes soliciting residents.

Conditional Licenses: Provided for new facilities that require only appropriate zoning changes to qualify for 6 months. Also for 90 days for change of ownership as well as for renewal if in process of administrative or court review.

Revocations: Facility can continue to operate if under Administrative Hearing unless injunction is applied by courts.

Inspections

Number of Inspectors: 23 team leaders in State. Direct teams in Districts composed of individuals from local fire and sanitation departments.

Assigned: District level assignments. Can also inspect other type facilities as Adult Day Care Centers in certain Districts.

Frequency: Inspections done annually. Some Districts quarterly or semi-annually.

Enforcement

Compliance:

- Technical Assistance - Provided by Community Mental Health Centers to aid Adult Congregate Living Facilities (ACLF) operators to deal with mental health patients.
- Penalties - Various financial penalties imposed for levels of administrative violations ranging from $100 to $5,000 depending on level of violation.
- Notice of Deficiency - Posted in facility. Requires plan of corrective action and follow up inspections.
- Court Action for Injunctive Release - When necessary to revoke license and stop operation of facility.

Public Opinion: Individual residents and general public can alert District Long Term Care Ombudsman Committees for help on individual compliance or possible unlicensed homes.

Incentives: Financial penalties, and publicity on bad actors.

Successes/Failures: Successes would include use of Voluntary District Ombudsman Committees. Failures would

include a shortage of beds for mental health clients undergoing deinstitutionalization. ACLF's don't always want such clients. Local community mental health agencies are working with ACLF's to provide assistance to operators.

Patients' Rights: Patients' Bill of Rights in Legislation covering wide range of rights including such things as management of funds, privacy, religious freedom, 30-day notice of eviction, use of personal clothes and possessions, freedom to move about and leave facility, etc.

Illinois

Agency for Licensing, Inspections and Enforcement

State Department of Public Health, Division of Health Facilities Surveillance.

Funding is through General Revenue.

Facilities Regulated

Division of Long-Term Care licenses all SNF, ICF, Community Living Facilities, and Sheltered Living Facilities.

The major difference between Community and Sheltered Living Facilities is that Community Living Facilities house mentally retarded persons and those taken out of State institutions.

Licensing

a. As of July 1, there were 863 licensed facilities in the State (includes SNF and ICF).

Board and Care type facilities

26 - Community Living Facilities
62 - Sheltered Living Facilities
1 - ICF/DD and Sheltered Living
58 - ICF and Sheltered Living
11 - SNF, ICF and Sheltered Living

Facilities which are combinations of sheltered living and ICF or SNF are licensed separately for each level of care. These facilities have to separate sheltered living from ICF or SNF by building or floor.

b. Outreach: There is no formal outreach program. The State does provide ongoing consultations (e.g., dietary), and they hold training sessions in a central location (3 or 4 places), to describe any major changes or revisions in the regulation. In these training sessions, all facility types are invited.

c. They have no conditional licenses to-date.

-Probationary licenses are issued to first-time licensees. No community or Sheltered Living facilities have probationary licenses.

d. When a license is revoked or denied, a facility has 30 days to correct problem(s). Effective date stated in the denial statement.

The State has the authority to immediately close down a facility and move residents. This is an emergency transfer in life/death situations. A facility has the right to appeal after closure.

Inspection

Approximately 55 nurses, 15 sanitations and 9 architects are regionally based (9 regions) to inspect facilities. Inspectors look at all types of facilities. In addition, Community and Sheltered Living Facilities have to be inspected by the local fire marshall.

Enforcement

Compliance Activities

(1) Technical Assistance -- facilities can request consultations.

(2) Penalties -- ability to issue conditional licenses; revoke or suspend licenses; and fine facility.

- o Type A facility: violations are a direct threat to life and safety of residents. Fine: not to exceed $4.50 per resident and 15¢ per day/per resident or not less than $1,000.
- o Type B facility: violations are an indirect threat to life and safety of residents. Fine: Not to exceed $3.00 per resident and 10¢ per resident/per day.
- o Type C facility: minor deficiencies and no direct threat to the life and safety of residents. Fine: not to exceed $1.50 per resident and 5¢ per resident/per day.

(3) Best Practices

-Department of Aging Ombudsman Program (Although directed more towards the resident than licensure/ inspection/enforcement issues).

-Licensed facilities report to State those facilities that are unlicensed.

(4) Patients' Funds

-This area is monitored by the Department of Public Aid.

-The inspection process does require that someone be bonded in facility to handle funds.

Oversight

-State Legislature's Auditor General.
-Department of Public Health's internal auditors.

Legislative Authority

-The Nursing Home Reform Act of 1979
Chief Sponsor - Senator Richard Daley, Jr.

-Effective January 1, 1982: The Community Living Facilities Licensing Act (S. 756)--Major changes from Nursing Home Reform Act--No fines or penalties will be imposed for non-compliance.

The State will still license and inspect according to requirements similar to old authority and will still be able to revoke or deny license.

Interested Group: Association for Community Living

State Data Exchange: State appears to have not used this service to identify Community or Sheltered Living Facilities.

Maryland

Agencies for Licensing, Certification, Inspection, and Enforcement

- Department of Health and Mental Hygiene - Division of Licensing and Certification (DHMH/DLC)
- Department of Human Resources - Social Services Administration - Adult Services
  - o Project Home
  - o County Welfare Offices
- Office on Aging - Housing

Facilities Regulated	Office Regulating
- Domiciliary Care Facilities	DHMH/DLC
- Foster Homes for Adults	Project Home/County Offices
- Group Homes	Project Home
- Supervised Apartments	Project Home
- Sheltered Housing	Aging

Licensing

- Number of licensed facilities

o Foster Homes for Adults	(Project Home)	45
o Group Homes		4
o Supervised Apartments	approximately	19
o Domiciliary Care Facilities		29
o Sheltered Housing		6
Total		103

- Home Finding
  - o Project home develops housing for project home participants.

- Provisional or Temporary Licenses:

    - o New facilities are given a conditional license for six months to assure that the facility's standards remain the same.

    - o For older facilities that do not pass inspection, a three or four month provisional license is given to allow time to correct the problem.

    - o Project Home does not give provisional licenses, however, individuals can be placed in homes prior to certification.

- How long can a facility continue to operate upon denial or revocation of the license?

    - o It can take as long as two years to shut down a facility that does not pass inspection.

Inspections

- Number of Inspectors

    - o Department of Mental Health and Mental Hygiene - Division of Licensing and Certification - 21 Inspectors assigned geographically, 6 vacancies.

    - o Project Home - 2

    - o Office on Aging - 1

- Obstacles to Inspection

    - o County welfare and health agencies are reluctant to identify unlicensed or uncertified homes.

    - o Lack of homes to place individuals acts as a disincentive to identify unsuitable homes.

    - o Lack of information from all groups involved with the placement of individuals in homes. Veterans Administration; SSI/SSA (lists are outdated); and public assistance.

Enforcement

- What means are used to get compliance?

  - o Penalties - in the form of closures.
  - o Frequent inspection of those facilities with identified problems.
  - o Bonding bill passed to assist with obtaining sprinklers by providing low interest loans.
  - o Small grants are provided to operators to upgrade facility - money is used primarily to buy sprinklers.
  - o Regulations have been revised to address levels of services offered by facilities.
  - o Payment rate structure has been improved.

- Do States bend or ignore rules?

  Waivers are given to facilities. Some of the most common are: number of bathrooms; wider corridors; visual alarm systems; and emergency generator requirements for homes with over 50 beds. Regulations and inspections usually bend rules in favor of older institutions.

- Patients' Funds

  - o Audits conducted once a year review use of patients' funds.
  - o Complaints of providers "doling out" money have been made--but not theft.
  - o The Office on Aging does not monitor the activity of patients' funds.

Michigan

Agencies for Licensing, Inspections and Enforcement

Administrative Services Section, Bureau of Regulatory Services, Michigan Department of Social Services

Division of Health Facility Licensing and Certification Michigan Department of Social Services

Facilities Regulated

Foster Care group facilities (4 types)

Homes for the Aged (to be moved into the foster care group structure March, 1984)

Foster Care Group Facilities

Licensing

Number of licensed facilities:

Foster Care Family Homes	- 2,061	
Small Group Homes	- 1,136	
Large Group Homes	- 199	
Congregate Care Facilities	- 24	
	3,420	Total

Homefinding: Department of Mental Health

Number of Provisional or Temporary: All homes are issued temporary licenses. Provisionals up to 3 consecutive years -- Regular licenses are 2-year duration.

Revocations: Has revoked, denied or refused to renew 160 facilities in 1981.

Inspections

58 Field Staff (4 additionals to be added in FY 1982) - All masters degrees in social work or related field.

Enforcement "Best Practices"

Michigan relies on the following ingredients for a 90% successful compliance rate.

1) Clear State statutory authority;

2) Excellent cooperation and support from the State Attorney General;

3) Strong enforcement posture by the agency;

4) An adequate number of well trained experienced inspectors who are capable of providing consultation to providers;

5) Quick turnaround time and responsible feedback when investigating complaints. (State law mandates complaint investigations to be conducted within 15 days of receipt. Agency policy requires 5 days for general complaints and 1 day for complaints of abuse.) Additionally, the complainant must receive a report of the findings from the Agency and may file for an administrative hearing upon disagreement with the findings.

6) State legislative commitment for oversight and building community resources. (Michigan's Zoning Enabling Act spearheaded by Representative David Hollister is considered a legislative landmark for enabling more good homes to be opened in communities.)

Homes for the Aged

Licensing

Number of Facilities	Ownership
18	Individual
6	Partnership
49	Corporations
39	Nonprofit Other (Masonic Home, Polish Army Veterans, Salvation Army, etc.)
6	Pending Review
124	

Homefinding: This group of homes is fairly stable. Any inquiries regarding new homes for licensing are handled by this Division; however, no new homes have been licensed over the last 2 years.

Revocations: 6 or more homes are presently under review for denial: Few revocations take place.

Inspections

60 consultants who work in teams review the homes yearly on a regular schedule. Consultants are nurses, sanitarians, dietitians, social workers and physicians.

Enforcement

Reliance on facilities' acceptance of standards.

Missouri

Agency for Licensing, Inspections, and Enforcement

Department of Social Services, Division of Aging

Funded via general revenue.

Facilities Covered

- Adult Boarding Facility - Provides room and board, personal care, 24 hour supervision, distributes medications, (1-40 staff to recipient ratio).

- Residential Care Facility - Provides higher level of care including dispensing and administering of medication. Below level of care provided by ICF. Staff to recipient ratio 1:15 (Day) and 1:20 (Night). Nurse monitors weekly. Dietary restrictions observed.

Licensing

Number of Facilities	Number of Beds
Adult Boarding - 336	7014
Residential Care - 49	2062

Outreach: Major effort done prior to passage of 1979 law. Follow-up now as reported.

Conditional/Temporary License: Probationary License issued only after notice of noncompliance to a facility and upon facility having a signed consent agreement. No temporary license issued to new facilities.

Revocation of License: Upon revocation, facility can no longer operate.

Inspections

Number of Staff: 19 Inspectors Statewide.

Assigned: Regional assignments. Head up team of licensed practical nurse and sanitarian.

Frequency of Inspections: Biannually. Follow-up in 55 days for corrections.

Enforcement

Compliance Mechanisms:

Penalties - financial penalties for noncompliance up to $1000/day.

- court imposes levels of misdemeanor.

Removal of Residents - Residents in immediate danger are removed to another facility.

Notice of Noncompliance - Notice sent to facility and required to be publicly displaced. Corrective action plan required. Consent agreement can be prepared until corrective action completed.

Public Opinion - Media coverage has been extensive. Issue in political campaign due to local fires.

Successes and Failures - New law passed in 1979 which has strict requirements for fire safety, personal rights, etc. However, lost a number of small homes due to their inability to pass new requirements for building and fire safety. Considering convening task force in State to review requirements for small homes.

Patients' Rights - Bill of Rights included in 1979 Legislation which includes 26 rights such as: funds protection, property handling, transfer of residents, grievance procedures, privacy, etc.

New Jersey

Agencies for Licensing, Inspections, and Enforcement

- Bureau of Licensing, Certification and Standards, Division of Health Facilities Evaluation, New Jersey State Department of Health.
- Bureau of Rooming and Boarding Home Standards, New Jersey Department of Community Affairs.
- Bureau of Operations, Division of Mental Retardation, New Jersey Department of Human Services.
- Office of the Ombudsman for the Institutionalized Elderly, New Jersey Department of Human Services.
- Office of Statewide Facilities and Support, Division of Youth and Family Services, New Jersey Department of Human Services.

Facilities Regulated

- Residential Health Care Facilities (formerly Boarding Homes for Shelter Care).
- Boarding and Rooming Houses (70 percent considered to be facilities which are now licensed under three categories).
- Family Care Homes for the Mentally Retarded (four types).

Residential Care Facilities

Licensing (Department of Health)

Approximate Number of Licensed Facilities - 225

(Approximately 10,000 beds with about half on SSI)

Number of provision or temporary - None

(Does not issue provisional licenses. The Bureau believes that the issuance of temporary licenses delay the process of obtaining full compliance.)

Revocations:

90 percent compliance; fines 9 percent; 1 percent revocation.

Inspections:

Five field staff all registered nurses. A physician, nutritionist, and pharmacist serve as consultants. Inspections include annuals, post-surveys, validation, surveillance, and complaint visits.

Enforcement "Best Practices:

Practices used to obtain 90 percent compliance are:

- Curtailment of admissions: If the facility does not meet minimum safety and health standards, the licensing bureau will not allow the facility to admit new clients.

- Assessment of Fines: The $25.00 per day fine for violations was recently changed to $250.00 per day.

- Community Welfare Boards are mandated to render services to residents of such facilities. Outreach visits mean that each home is visited by the caseworker every six months. Comprehensive files on all facilities are available through the county welfare system.

- Complaints received on Residential Care Facilities and on Boarding Homes are referred to appropriate State agencies, including the licensing bureau for remedial action and follow-up.

Rooming and Boarding Homes
(Three Levels of Care)

Licensing:

Department of Community Affairs

Number of Temporarily Licensed Owners and Facilities	-	735
Estimated Rooming Houses	-	2,000-3,500

(The Department estimates that the rooming house population is about 30,000 about half of residents are on SSI.)

Provisional or temporary licenses - The majority of these facilities are still unlicensed because uniform standards for boarding homes were not developed until 1981. The Bureau of Rooming and Boarding House Standards has been in existence since July, 1981. These homes are being given a temporary license until both a physical and social needs evaluation can be made.

Inspections:

Staff now consists of 6 physical and 12 social needs evaluators. Due to lack of staff, municipalities are assisting in inspections.

Revocation:

Due to recent legislation, Rooming and Boarding Homes that are not licensed are being closed down. Nine homes have been closed and 330 individuals have been relocated.

Enforcement

- The Bureau believes that it will be effective in obtaining compliance because it has clear State statutory authority to revoke licenses and close down homes.

- Coordination with the Bureau of Licensing in the Department of Health has made it possible to close down residences that are known violators of health, welfare and safety standards.

- Enforcement of minimum standards has resulted in a bed shortage of quality homes. Inspections have revealed that 10-15 percent of the residents need a higher level of care.

- The Department hopes a State and Federally supported life/safety grant and loan fund can be established in the Department of Community Affairs to finance needed corrections. A low interest loan fund or plan of reimbursement which will help owners to finance capital improvements must be created if homes are to make capital improvements. This is a critical issue in terms of both the correction of deficiencies and of keeping these homes open.

Family Care Homes for Mentally Retarded

Licensing (Division of Mental Health)

Number of Licensed Facilities:

Family Care Skilled Development	-	540
Group Home Supervised Apartment	-	69
Total	-	609

During 1981, eighty-two licenses have been suspended. Temporary licenses are given until violations are corrected. A high degree of compliance is obtained. New facilities are not licensed until standards are thoroughly reviewed. New facilities are inspected after six months, thereafter annually. During 1981, ten percent of the facilities applying for licensure were rejected. After reinspection, six percent met standards, four percent were denied licensure.

Inspections

Training is given to all operators and owners. Inspections are done annually. The investigative staff total 17.

Enforcement

The Division of Mental Retardation believes that its standards are effectively enforced because:

- A stringent review scrutinizes all new applicants for licensure. Training is given to all operators and owners.
- When violations are noted, written correction plans must be submitted by the facility.
- In addition to annual inspections, a 20 to 30 percent sample of unannounced visits is made. Facilities identified as potential violators are double checked in this manner.
- Communications between case management and the licensing bureau is good. The different responsibilities of each agency are clear.

New York

Agency/Agencies for Licensing, Inspections, and Enforcement

- Department of Social Services, Division of Adult Services (DSS)
- Office of Mental Health (OMH)

How Funded:

DSS/OMH: General Revenues from State

Facilities Regulated:

DSS: Residential Care Facility for Adults - Provides 24 supervision for 5 or more adults. Includes room and board, housekeeping, personal care, social activities, supervision over self-administered medication, dietary aides.

Family Type Homes for Adults - Provides similar services as noted above except for 2 to 4 adults. Inspection and enforcement handled by local Districts with final licensing approval from State.

OMH: Supervised Community Residence Housing - Provides 24 hour supervision for generally 12-24 individuals, personal care, means prepared by staff and residents, residents aid in housekeeping, supervision over self-administered medication. Non-Profit.

Licensing:

Number of Licensed Facilities:

DSS: 527
OMH: 80.....2209 Beds

Temporary/Probational Licenses:

DSS: Issues 6 month Operating Certificates for new facilities which require minimal conditions for final compliance. Only done on special cases.

OMH: Issues 6 month Provisional Certificate which must be reviewed (inspected). Based on the inspection, can give facility another 6 month Certificate or issue one year Certificate.

Revocations:

DSS/OMH: Upon denial or suspension of License, a facility can continue to operate until legal hearing process is completed. State can close down facility immediately if it poses a danger to residents. DSS or OMH would seek court action to obtain receivership if necessary. OMH has not revoked a license in past 6 years - due perhaps to smaller program with close monitoring.

Inspection:

Twice a year, 1 announced, 1 unannounced.

Number of Inspectors:

DSS: 40 Statewide

OMH: 7 Statewide

Assigned:

DSS: By Region. Inspectors head up team comprised of fire safety, program and nutritionist specialists. Considering adding a nurse to team.

OMH: By Region. Inspectors can call on specialists as necessary. No formal team concept.

Enforcement:

Technical Assistance:

DSS: Inspections teams aid operators in handling corrective actions. Provides local training resources to operators where needed.

OMH: Developing a training program for operators on: administrative/management concerns; handling of medications, case management, maximizing use of community resources, record management. Curriculum being field tested.

Penalties:

DSS: o Can enforce financial penalties up to $1,000/day for unlicensed facilities that continue to operate.

- o Can issue administrative orders to correct.
- o Can revoke or deny renewal of license.
- o Can reduce level of care so facility is no longer paid at a Level II.
- o Can seek Court Order from Supreme Court (lowest level of Court for general jurisdiction) for emergency stop gap to close facility.

OMH:

- o No financial penalties.
- o Can revoke license - but none done in past six year.
- o Provides close monitoring by inspection staff.

Public Opinion:

DSS: General information pamphlets available. Starting a public information campaign this Fall on protective services for adults.

OMH: Maintains a low profile. Prefers to work closely with community and facility in low key way - most successful.

Incentives:

DSS: Considering providing additional funds for larger facilities that have higher, unique operating costs. Could result in sub-categories in Level II care. Also considering additional funds for those facilities providing greater personal care due to larger number of mental health clients.

OMH: Financing still an incentive for most facilities. Not true in certain locations where costs (rent, food, etc.) are higher than State average.

Successes/Failures:

DSS: Program Development - Contract with local mental hygiene providers for homes with high number of mental health clients to aid in teaching and coping skills. Providers include churches, volunteer agencies, etc.

Personal Allowance - Protected by law that all residents receive at least $47 a month for personal needs. In addition, 70 percent of SSI recipients receive another $20 as a Federal disregard.

OMH: Facilities are nonprofit. Having problems closing down large mental institutions due to community resistance and union resistance.

Pennsylvania

Agency for Licensing, Inspections and Enforcement

1) Department of Public Welfare

   a) Office of Social Programs
      Bureau of Adult Residential Services

   b) Office of Mental Health

   c) Office of Mental Retardation

2) Department of Aging

Facilities Regulated

1) Personal care homes with four or more residences

2) Community Rehabilitation Residences

3) Community Living Arrangements

4) Domiciliary Care Units

Personal Care Homes

Licensed: Approximately 475 homes (including provisional)
In licensing process: approximately 225 homes
Possible Universe: 1500 homes

Provisional Licenses are issued for a maximum of six months, though they can be renewed three times (so the process can take two years) if the facility is making progress towards compliance with licensure standards.

Licenses denied - four since the new board and care regulations were issued on June 19, 1980. Homes can be closed in a maximum of 30 days, and immediately if life safety issues are involved.

Inspections

Pennsylvania is divided into three regions. Each region has six inspectors and a supervisor. "Fire and panic" regulations are stricter for facilities for nine or more residents.

Enforcement "Best Practices"

- Inspectors have received training to assist the operators to come into compliance when they do not meet standards.

- The State has a training program for operators that is now voluntary, but will be required within a year. Training for operators covers thirteen areas of board and care homes. A survey indicated that only 20 percent of board and care operators are now knowledgeable in all thirteen areas.

- The Department of Public Welfare has sponsored a pilot workshop in coordination of the efforts of agencies (e.g., hospitals, clinics, State personnel) and providers. As a result, both agencies and providers 1) wanted future workshops and 2) established goals and action steps to implement those goals.

- The State has a complaint program which is advertised in the newspaper and in media spots. They encourage--and get--referrals from social service agencies and other board and care providers.

Domestic Care Units

Licensing

Local level Area Agencies on Aging, (AAA), which report to the State Department of Aging.

The Program

- 700 homes now licensed, chosen to provide a family-like setting.

- Only residents of these homes receive SSI State supplementary payments ($147.30).

- Eighteen placement agencies (under the AAAs) over 30 counties operate the program.

- Caseworkers provide ongoing monitoring, with monthly visits to the residents.

- There is an agency/provider agreement and a provider/client agreement, signed by both. The agreement includes, for example, house rules and menus.

- 1,240 people participate in the program.

- The Department of Aging plans to expand the program to cover all 61 of the States' counties by 1984.

- The entire program, including supervisors, caseworkers and support staff is run by 106 people.

North Carolina

Agencies for Licensing, Inspections, and Enforcement

(1) Licensure and Certification Section, Division of Facility Services, North Carolina Department of Human Resources

(2) County Departments of Social Services

Funding:

Title XX, some State licensing money.

Facilities Covered

Family Care Homes (capacity 2-5)

Homes for the Aged and Infirm (capacity 5±)

Group Homes for the Developmentally Disabled (capacity 2-9)

Licensing

Number of licensed facilities:

Family Care Homes	569
Homes for the Aged	304
Group Homes for the Developmentally Disabled	99
Total	972

Licensed homes growing at a rate of about 20 per year.

Current regulations (issued 1976; now being revised) state that a provisional license may be issued for up to one year enabling a facility to operate while problem is being corrected. Usual duration is now 30-90 days. Though the provisional may be extended if another violation is discovered, it will not be renewed for the same violation, and no regular license will be issued. Regular licenses are 12 months in duration unless revoked for cause. They may be renewed annually upon rereview and evidence of continued minimum compliance. Bi-annual building inspections will be required as well, beginning this year.

Revocations:

Have revoked, denied, or refused to renew fewer than one dozen facilities in the last year.

Denial or revocation of license--becomes effective 30 days after mailing notice unless applicant requests a hearing, in which case denial or revocation is temporarily suspended. Hearings are usually conducted within 30-60 days and the decisions of the Division of Facility Services upheld.

Inspection:

Responsibility of county social workers in each of North Carolina's 100 counties.

The State law mandates monthly visits to all licensed group homes. . . .which may be, and often are, unannounced.

Enforcement

Means used to get compliance:

(1) Tight rules and regulations;

(2) monthly visits and reduction in provisional period for coming into compliance with standards;

(3) prompt "cease and desist" orders on facilities not in compliance; and

(4) active and strong support of a "Long-Term Care Facilities Association"; composed of group homes proprietors, whose interest is in quality of care and increasing State supplement for residents.

Best Practices

Strict enforcement of standards; TA to operators; information exchange with group homes association; frequent spot checks of facilities; and adequate number of well-trained inspectors.

Patients' Funds

North Carolina has a new law effective 10/1/81 dealing with patients' rights in board and care homes. Checks on patients' funds up till now have involved situations where there is a representative payee.

State Supplementation

North Carolina supplements Federal SSI checks for residents of licensed domiciliary care homes only. The amount of the supplement varies based on the degree of ambulation of the patient.

Virginia

Agency for Licensing, Inspections, and Enforcement

The State Department of Welfare - Division of Licensing, Bureau of Licensing Management

Facilities Regulated

Homes for Adults

Licensing

Number of licensed facilities are approximately 319 with 11,194 beds - Most homes are operated for profit. No outreach services performed by the State.

-- Regular license issued for 12 months.

-- Conditional and provisional licenses issued for six months. Extensions can be granted for fire safety problems.

Inspectors required to have degree in social work or a related field and four to five years work experience. Assigned by regions.

Enforcement

Procedure of unannounced inspections, denial, revocation, injunction and referral to renew licenses. Since the number of unannounced inspections, more violations are being uncovered.

Survey of State Placement, Resources and Referral Practices

The SSI program allows eligible persons in institutions to apply for SSI benefits before their release. Eligibility for SSI is based on age or disability, income and resources. GAO, in their study on Returning the Mentally Disabled to the Community, found that mental illness ranked second and mental retardation third among the primary disabling conditions of recipients. SSI allows and discharged patients may pay for housing in any type of community facility.

According to the Service Delivery Assessment on Boarding Homes, placement is often more by default than design, particularly by mental health institutions. Persons may place themselves with little or no discussion with the institution; or may be referred or told about a facility; or may be discharged with a structured plan of supervision. Such placements range from no knowledge or controls by the discharging hospital about patients' whereabouts, to a highly organized plan of patient follow-up.

Mentally retarded individuals are more likely than mentally ill to be discharged into licensed facilities with a structured plan of supervision. This review however has shown that mental health hospitals collect aggregate data only on the number of patients discharged, not on where or how. This means that hospitals not only do not collect statistics on how many persons are released on their own devices, but also may not know how many persons have hospital aided discharge plans.

One State, however, which has made great strides toward successful placements of mentally retarded individuals and is a "best practice" State for enforcing its own licensing standards for group facilities, indicated that less than 20% of the mentally ill patients are placed through a formal discharge plan into a structured community based facility. The other 80 percent -- 70 percent of whom entered the mental hospital involuntarily, are discharged on their own resources. Many of these persons are the residents of boarding homes, hotels and other facilities which may have been licensed (but more often not) by local jurisdictions.

States were asked the following questions:

(1) What percentage of the mentally ill patients were discharged with a) structured plan to a particular type facility; b) self arranged plan-may include information and/or referral by the hospital to a facility; c) unknown plans-no information or discussion by the hospital with the patient? States answered as follows:

State	Hospital	ADMITTED FY 80-81[1]			DISCHARGED FY 80-81				
		Total	Voluntary	Involuntary	Total	With Structured Plan	Self Arranged[5]	Refused	Unknown
California	Santa Clara Valley[2] Medical Center								
	Napa Valley State Hospital	2653	12%	88%	2686	7%		3%	90%
District of Columbia	St. Elizabeth's[4] Hospital FY 80	3685	N.A.	N.A.	3780	31%[3]	N.A.	N.A.	68%
Florida	South Florida State Hospital	1188	55%	45%	577	88-90%	6%	6%	
Illinois	Elgin Mental Health Center	1514	72%	28%	2218	13%	82%	5%	
Maryland	Springfield Hospital Center	3011	23%	72%	2624	43%	35%		21%
Michigan	Northville Regional	8930	12%	88%	4033	14%	N.A.	N.A.	85%
New York	Pilgrim Psychiatric Center	1052	40%	60%	630	35%	N.A.	N.A:	
North Carolina	John Umstead Hospital	3033	34%	60%	3066	6%	N.A.	N.A.	
Pennsylvania	Harrisburg State Hospital	272	27%	73%	258	81%	3%		5%
Virginia	Eastern State Hospital	4556	41%	59%	2042	4%	N.A.	N.A.	

N.A.- Not available. FY 80-81 data not collected.
1/The total number discharged does not correlate with the total number admitted.
2/Santa Clara Valley Medical Center could not retrieve the requested data.
3/The percentage may not total 100% because numbers given did not always convert to percentage tables.
4/The data for St. Elizabeth's is for FY 1980.
5/May represent return to home.

Springfield Hospital Data Collection Project (Maryland)

Springfield hospital in Sykesville, Maryland, recognizing that "dumping patients in the community" is a major criticism faced by the hospital, has begun an effort to collect data about how and where patients are placed. The data obtained will be used to provide a comprehensive picture of the hospital's placement activities thereby making it possible to answer allegations of inappropriate placements. The data will also be used to help staff become knowledgeable about the impact of client placement. The long-run plans are to use the information to determine the impact placement has on recidivism. Major problems associated with this effort are staff's failure to report necessary data and the lack of time to complete the necessary forms.

Some of the data elements collected are:

1) Discharged - placed through Social Worker's efforts

2) Discharged - Social Worker not involved in the placement

3) Type of facilities in which placement is made -

   Legal boarding home
   Board and Care Facility
   Foster Care Home
   Illegal Boarding Homes

BEST PRACTICES

Maine
Training for Board and Care Operators

Maine was awarded a training grant to ensure that board and care operators develop a level of competency for dealing with difficult patients; and to provide strong training linkages between the local Community Mental Health Centers (CMHC's) and local board and care operators.

This two year training grant ($48,000) from the Center for State Manpower Development/NIH was a supplement to a Manpower Commission grant conducted by the Maine Department of Mental Health and Retardation. The Department contracted with the Maine Council of Community Mental Health Centers which represents all of the CMHC's (8) in the State to provide training to board and care operators in the following program areas: 1) dealing with chronically mentally ill clients; 2) psychotropic medications; and 3) activity coordination and planning.

The grant is in two phases--1) assessment of training needs; and 2) development and implementation of model training programs. Training began in January, 1980 and is expected to be completed by the end of this year. To date, 410 board and care operators have received training. Formal evaluations have not been performed.

Maryland
"Project Home"

In 1976, an Interagency Committee on Domiciliary Care was created by the Governor to study the problems surrounding domiciliary care in Maryland. Based on recommendations made by this committee, Project Home was established on July 1, 1978. Its purpose is to develop and certify adult residential environmental (CARE) homes for deinstitutionalized mentally ill clients; facilitate the placement of the clients in CARE homes and to prevent reinstitutionalization of these clients by providing ongoing case management services in the community. Project Home is administered by the Social Services Administration of the Maryland Department of Human Resources.

Project Home's initial mandate was to demonstrate the feasibility of a domiciliary program that would meet the housing and support needs of disabled adults and frail elderly who did not need nursing homes and large State institutions. In 1979, House Bill 1426, which provided for the administrative release of mental patients was passed. The Department of Human Resources and the Department of Health and Mental Hygiene designated Project Home as the vehicle for the implementation of this bill.

In order to implement this mandate, budget resources were allocated to three areas: 1) staff positions (10 positions--$229,212); 2) State SSI supplementation to deinstitutionalized clients--$621,182; and 3) grants to nonprofit groups to help upgrade facilities, i.e., purchase of sprinklers or other fire deterrent equipment, kitchen utensils, etc.

To date, Project Home is operating in 6 counties and has developed 45 foster homes for adults, 4 group homes and 19 supervised apartments. As of January 1981, 77 deinstitutionalized clients were placed in homes-twenty-three returned to the State hospital.

Maryland
"Project Identification"

Project identification was established to identify and license boarding home facilities which provide domiciliary care for the aged and disabled persons in the State of Maryland. Recognizing boarding homes as a major source of criticism Maryland has set out to identify boarding homes which by virtue of their occupants and treatment thereof should be classified as domiciliary care facilities and licensed appropriately.

The project is in four phases. The first phase consists of refining and combining lists from the Social Security Administration (SDX tapes); State and local welfare departments and the Veterans Administration office. Local welfare and public health departments staffs have conducted most of the survey interviews while the Division of Licensing staff (two nurses and one supervisor) have conducted the balance.

In the first phase, boarding home operators who are often old, widowed and living on marginal incomes, are informed that the State is conducting a survey about the facility and its residents. The survey consists of comments from the residents and operators about services and conditions of the home and observations by the inspectors.

The second phase will consist of re-interviews for sorting and validating preliminary findings. During this phase, homes which appear to need licensing will be selected.

The third phase will consist of a request to and response from operators who will be asked to apply for domiciliary care licenses, if they appear eligible.

The fourth phase is enforcement. This phase is highly dependent upon resolutions and negotiations with the State fire marshall. It is anticipated that by the third phase, Maryland should have negotiated what they consider "reasonable" fire and safety standards for homes. Such standards would not require sprinkler systems, but would require smoke and health detectors linked to an audible alarm system to serve as an early warning signal in case of fire. Other requirements such as fire retardant paint on sleeping room doors (or walls); good evacuations, (two ways

of egress with fire escapes for higher buildings); and annual physical examinations of residents to determine if they would be able to take necessary action for their own preservation, are thought to be essential.

If these standards survive and Project Identification is effective, Maryland shall have identified all nonlicensed homes which provide board and care type services and can thereby begin to regulate their existence in some meaningful way.

New Jersey

New Jersey views the development of a large boarding home population in New Jersey, and throughout the United States, as a problem of housing and economics. This State believes that the growth of the problem is related to the large increase in the elderly and disabled populations, the shift in national attitudes with regard to care in large institutional settings, and most notably the impoverished economic condition of many elderly and handicapped.

As such, since 1977, New Jersey has embarked on a State reform program. Major legislation in this area resulted in the enactment by the New Jersey legislature of a model law, the Rooming and Boarding House Act of 1979, and in the passage of the Federal Mental Health Systems Act, part of which was modeled on New Jersey legislation.

At this time, certain aspects of the State reform program have been put into place while further action is needed for both life/safety improvements and for the general upgrading of the quality of care.

Four aspects of New Jersey's analysis of the problems and processes for reform are offered as "Best Practices".

Statewide Regulation of Complaints

Under the Rooming and Boarding House Act of 1979, New Jersey mandates that complaints concerning services and conditions at residential health facilities, rooming houses and boarding homes be made to the Commissioner of Human Services.

The State operates a hotline (in conjunction with its Child Abuse Hotline) which makes its investigations within 24 to 72 hours. The results of these investigations are then reported to the county welfare boards who render direct service to residents of such facilities and who are mandated to investigate these complaints.

The Office of the Ombudsman for the Elderly is further mandated under this act, at a minimum, to refer all complaints received concerning services and conditions at such facilities to the Commissioners of Human Services, Community Affairs and Health. This office, in conjunction with the Department on Aging, investigates and reports on all complaints concerning patients

rights and facilities servicing the elderly. In addition to maintaining their hotline, five nurses and three professionals serve as field staff.

This means that in New Jersey there is Statewide regulation of the reporting of complaints and instances of abuse and neglect with strong follow-up and communication with the difference licensing agencies.

Posters that advertize the different numbers that can be called to make complaints are posted in every facility.

Three-Tiered Communication System

A three-tiered system which includes representatives from all departments and agencies at all levels effectively serves to facilitate the State boarding home reform program:

1. The Boarding Home Policy Coordinating Committee composed of the Commissioners of the Departments of Human Services, Community Affairs, and Health, and of the Ombudsman for the Institutionalized Elderly is mandated by the Rooming and Boarding House Act to meet on a continuous basis. The committee develops and reviews Statewide policy for the departments and agencies concerned with residential health care facilities or rooming and boarding homes.

2. The Interagency Boarding Home Coordinating Committee is composed of mid-level managers who represent the various departments and divisions charged with the licensing, inspection, enforcement, referral or placement programs for residential care facilities or rooming and boarding houses. Representatives from the County Welfare Boards who coordinate services and outreach at the local level are also present at these meetings. This committee reviews problems and policy and sends recommendations to the Policy Coordinating Committee.

   A subcommittee of this group is the Implementation Committee. Representatives from six counties and regional offices meet every two weeks to discuss implementation procedures and policy. For example, recently this committee has been examining the roles of the agencies best suited to close down facilities and relocate residents. The pros and cons of assigning this function to either the county welfare agencies or to the State licensing bureaus are being discussed, i.e., the county welfare agencies have the

best perspective on local operators and facilities, while the State licensing agencies have the better perspective on Statewide licensing standards. A policy decision will be made on this issue after all interagency representatives have contributed.

3. Remediation Committee is composed of county based representatives who provide services or have concern for the welfare or residents of residential care or boarding home type facilities. These committees meet monthly in several large counties where large concentrations of facilities exist. Representatives from agencies such as the County Board of Health, Mental Health, Community Health, Housing, etc., along with representatives from the licensing bureaus and direct service providers review local facilities. These committees also have units known as remediation teams who assist facilities in making changes necessary for compliance with the new standards.

Patient Funds

In order to protect its residents from unscrupulous operators who force residents of unlicensed homes to turn over their SSI checks, part of the Rooming and Boarding House law states:

> Section 18-25:
>
> The Commissioner of Human Services shall, at a minimum: (1) provide the Commissioners of Community Affairs and Health with such information consistent with Federal law and regulations concerning the disbursement of Supplemental Security Income checks. . . .as may be necessary to implement their duties under provisions of this act and prevent fraud and improper payment, and work with the Federal Government to ensure close supervision of the disbursement of such checks. . . .

The most common economic complaint in New Jersey is the mishandling of patients' funds. Until the new Rooming and Boarding House Act of 1979 was passed, no statute protected recipients from predatory operators. The new State Attorney General considers this a high priority matter.

North Carolina

- State only supplements SSI recipients living in licensed domiciliary care facilities, thus providing an incentive for homes to apply for licenses and comply with licensing requirements.

- Voluntary Oversight - Proprietors of domiciliary care homes have organized into an Association of Long-Term Care Facilities which, over the last six years, has assumed an increasingly active role in policing the homes and promoting quality care. In addition, they are actively lobbying the State Legislature to increase support (i.e., State supplementation) for residents of the homes, as an alternative to SNFs or other forms of institutional care.

  The Association requires a set number of hours of continuing education, provided through the Association, prior to membership approval and now claim to represent ca. 90 percent of all domiciliary care beds in the State. They have also just instituted a peer review process for their members, though it is too early to judge its effectiveness.

CONCLUSIONS AND RECOMMENDATIONS

1. Designate a Single Unit Within the Department of HHS.
2. Clarify Procedures for Certification and Publication of Standards.
3. Supplement existing Keys Amendment Sanction.
4. Make Medicaid, Home and Community Based Services Waivers Contingent Upon Licensing Compliance.
5. Make Representative Payee System More Accountable.
6. Increase Technical Assistance to State and local governments.
7. Develop a Model State Statute for enforcement of Keys Amendment requirements.
8. Complete Development of Model Fire Safety Standards.

Conclusions and Recommendations

The major finding of this study is that there is widespread confusion over the distinction between boarding homes and board and care homes, and that the Keys Amendment does apply only to board and care homes. States, as this review shows, have established standards for board and care facilities, i.e., those group living residential facilities which provide "protective oversight."

Nationally, there are approximately 30,000 board and care facilities usually under the licensing authority of one or two agencies within the State. Such agencies managed to ensure the enforcement of standards in most of the facilities on a yearly basis. On the other hand, boarding homes, (room and board facilities) are often not licensed by the States, are of unknown quantity (roughly 300,000), but are usually looked upon as being a "local" responsibility. Some of these facilities may receive an occupancy certification--which means that they are in compliance with local fire safety standards.

However, based on the legislative history, regulations and the fact that the penalty provision of the Keys Amendment addresses only those homes that provide some protective oversight, we have concluded that the Keys Amendment addresses standards and enforcement for board and care facilities, i.e., those boarding homes that provide some protective care for their residents. The law does not extend to boarding homes that are simply lodging places. While Congress could decide to extend the scope of the current legislation to include boarding homes, the Inspector General cautions against expanding a law that is already difficult to administer into an area that is even more difficult to regulate from the Federal level. Our recommendations, therefore, relate only to board and care facilities, although some of the technical assistance recommendations such as information sharing and development of model standards could be applicable to both.

Designate a Single Unit Responsible for Board and Care Activities

In his testimony before the Select Committee on Aging, the Under Secretary indicated that the Secretary was considering designating a single unit within HHS to undertake the overall responsibility for the Department's activities regarding board and care facilities. Our examination of the Department's current studies and other efforts strongly support the Secretary's position.

- Therefore, we recommend the Secretary should designate a single unit to oversee and coordinate Departmental concerns associated with board and care facilities and related boarding home issues. The unit should be charged with Departmental leadership for the board and care home issue and specific functions should include responsibility for: 1) approving proposed Departmental studies to ensure quality and non-duplication of content and efforts; 2) Federal technical assistance activities; (including model statute materials) to ensure that States are receiving useful information; and 3) coordinating Departmental policy and procedures regarding board and care issues to ensure compliance with pertinent statutory/regulatory provisions.

Publication of Standards and Certification of Compliance

The original Keys Amendment, at Section 1616(e)(2), required States to publish a summary of Keys standards in the annual services plan under title XX. In addition, States were to certify their compliance with the Keys requirements to the title XX component of this Department. However, the Omnibus Budget Reconciliation Act of 1981 converted title XX to a block grant program and eliminated the annual services plan. As a result, although the Keys Amendment still requires publication of standards, it no longer specifies the vehicle for publication.

- Therefore, we recommend that the Department identify a specific mechanism for States to use to publish Keys standards. Further, the Department should identify a single organizational unit within HHS to receive the States' certifications of compliance.

Sanction

The Department should devise an alternate sanction to facilitate more effective enforcement of the Keys Amendment. Within the context of the SSI program, any withholding of Federal funds would have the un undesirable effect of directly reducing payments made to SSI recipients (as does the existing law), and therefore provides little incentive for States to comply with the requirements concerning standards. Further, such a penalty levied against the recipients of SSI benefits seems patently unfair, and at best an indirect means to the end of improving standards. A more direct approach would be to take action against a State which does not adequately enforce its standards. However, since no Federal SSI payments are made to States, the only alternative is to reduce Federal grant monies given States under another program. Congress has recently involved activities funded under the Older Americans Act in the effort to improve conditions in facilities covered by the Keys Amendment.

Alternate penalties would not, however, be without drawbacks. Ultimately, because the Federal government does not provide direct funding to board and care homes, any financial sanction on States could have the effect of penalizing the intended beneficiaries of the Federal grant program. Therefore we recommend:

- In light of the need to encourage States to comply with the Keys Amendment the Department should develop a sanction to apply where a State is not meeting the statutory requirements. This would increase the Department's leverage and properly focus on the States' responsibilities regarding these facilities.

Implementation of the Home and Community Based Services Waiver (P.L. 97-35)

The Inspector General recognizes that the regulation of boarding homes is a responsibility of the States, and has therefore recommended against broadening the current scope of the legislation. We do believe, however, that when protective oversight is needed by residents of a boarding home, the home should be referred for licensing assessment according to the State's board and care licensing standards.

It is relevant to our recommendations to note that SSI beneficiaries are categorically eligible for medical assistance under Title XIX of the Social Security Act (the Act). Under Section 1915(c) of the Act, as amended by Section 2176 of the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, States may seek waivers from the Secretary to broaden the definition of medical assistance in order to provide for a variety of home and community based services to Medicaid eligibles, who, but for the provision of such services, would otherwise be institutionalized in ICFs or SNFs at higher costs. Under the statute and regulations (42 CFR 441.302, added 46 Fed. Reg. 48,541 (October 1, 1981)), to obtain a waiver States, among other things, must provide HCFA with satisfactory assurances that:

> "necessary safeguards have been taken to protect the health and welfare of the recipients of the services.... If the State has licensure or certification requirements for any services or for any individuals furnishing services provided under the waiver, it must assure that the standards in the licensure or certification will be met. 42 CFR 441.302(a)."

- We recommend that this regulation be revised to provide that to the extent that a State requests a waiver to provide medical assistance payments for services provided by board and care homes subject to the Keys Amendment, that the Secretary grant waivers only where such facilities included within the request meet the State standards required by Section 1616(e)(1) of the Act.

Better Use of the Representative Payee System Needed

The GAO indicated in testimony of June 22, 1981 before the House Select Committee on Aging that misuse of resident's funds by boarding home operators was a problem in several States. Additionally, the American Federation of State, County and Municipal Employees of the AFL/CIO recommended in a letter to the Committee that a CPA audit of financial statements be required from boarding home operators. Based on OIG Audit Agency experience in reviewing CPA audits required in other programs, we would suggest that this approach is too costly, not only for the operators but also for the agency required to review and provide oversight for the activity.

Instead, we are recommending the use of the already established representative payee system. Currently, when SSA determines that an SSI recipient is incapable of handling his or her own funds, payment is made to a third party on his behalf (20 CFR 416 Subpart Q). The representative payee is preferably a close relative or legal guardian. When no more preferable payee can be found, however, SSA may send the payment for the recipient to a person with a proprietary interest, such as a boarding home operator. SSA requires representative payees to use the SSI payments for the needs of the recipients and to account for the use of the payments upon request.

In those board and care facilities which should be licensed and inspected by the State, SSA has an opportunity to check on compliance with applicable standards. Therefore, we recommend:

- SSA should approve representative payee status to board and care proprietors only if the proprietor submits to SSA evidence of compliance with applicable State standards.

Increased Federal Technical Assistance

This review has shown that State problems regarding licensing, inspections and enforcement of standards in board and care and/or boarding homes are similar. Progress being made toward solutions of those problems vary widely from State to State--largely dependent upon the degree of interest and effort shown by States. Some States, like New York, which have made progress in developing standards regarding licensing and inspections nevertheless report difficulty closing sub-standard facilities. It is clear that the Federal Government could facilitate an information sharing process among States, and as this review has revealed, the States express a need for this information sharing to occur. Therefore, we recommend:

- The Department should increase its efforts to provide supportive assistance through legislative models, clearinghouse services, fire and safety standards, best practices information, etc., all aimed toward helping States better protect the lives of its citizens who reside in residential non-medical group living facilities.

Development of a Model Statute

All States included in this review indicated that a workable statute was of great importance for enforcing standards. Many of the States also indicated that their own statutes, which were often initiated in reaction to disasters, have been modified within the last five or six years. Improvements have been made as States gained more experience with the problems of board and care homes. This review has already begun to collect State statutes which could serve as an initial compendium of information. However, in order to guide States in drafting statutes (or amending existing legislation) we recommend the following:

- The Department prepare a model State statute governing standards in board and care facilities. This statute should address all relevant issues to ensure that individual State statutes would be comprehensive in scope. This would promote high standards in State laws, and thus increase public confidence in the quality of board and care homes.

Development of Model Fire and Safety Standards

Representative Martha Keys, in her testimony before the House Select Committee on Aging, June 1977, speaking to the variety of small residential facilities stated, "to get one Federal standard would not provide the flexibility which is desirable in these circumstances." The Department has therefore not attempted to impose a Federal standard. However, it is equally impractical to have each State, independent of the others, developing fire and safety standards. Our review showed that States are having difficulty determining adequate fire and safety standards for board and care homes. Therefore, we recommend:

- The Department should continue its funding to the National Bureau of Standards for development of the Fire Safety Evaluation System for board and care homes, to ensure that the standards, which can serve as a model for State and local standard setting agencies, will become a part of the Life Safety Code. Given the level of investment already made and the high return (development of model fire and safety standards) we believe the Department should make every effort to finish the work currently underway by the National Bureau of Standards.

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